AMEDD Patient Safety Program
A Dental Focus

Dental Patient Safety Coordinator

August 10, 2006

Title 10 U.S.C., Sec 1102

- Display of aggregate data and information in this briefing is considered medical quality assurance information that is protected from discovery by Title 10 U.S.C., Section 1102.
- Do not release without proper authority.
- Willful disclosure may result in fines up to $3,000

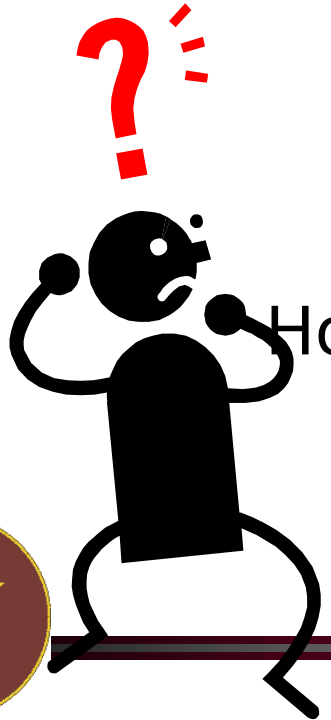
INTRODUCTION

- Patient Safety Overview
- Addressing harm in healthcare: AMEDD Patient Safety Philosophy
- Effect a culture of safety
- AMEDD Reporting and Event Data

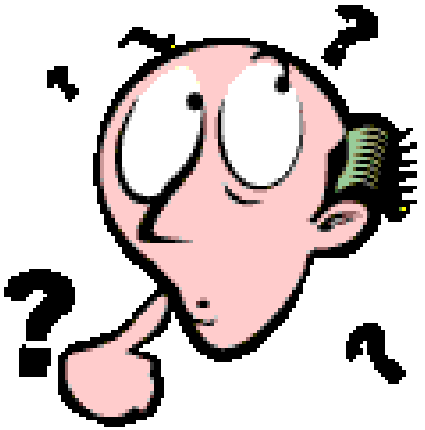
Why Patient Safety?

What is Patient Safety?

How can we improve what we do to keep Patient's Safe?



How will this change what we do?



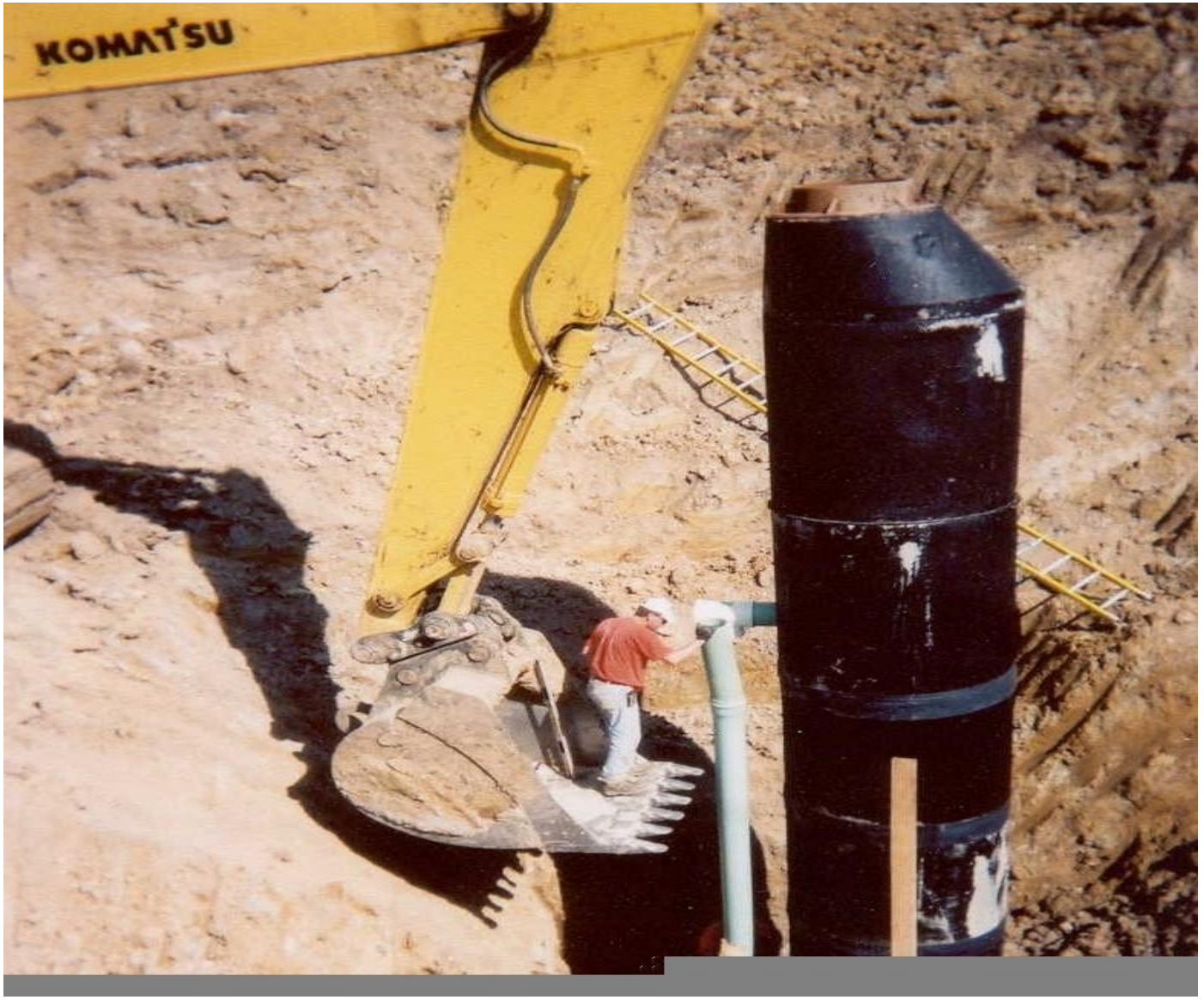

off the mark
by Mark Parisi
www.offthemark.com
SORRY, THE DRILL SLIPPED...BUT IF YOU EVER WANTED A TONGUE STUD, NOW WOULD BE THE TIME...
www.offthemark.com
MarkParisi@aol.com

Why should DENTACs participate in Patient Safety Programs?

- The Dental Services are an integral part of health care for soldiers and beneficiaries.
- Dental Care Initiatives are consistent with many of the AMEDD Patient Safety Initiatives
- Systems improvement will help to make the Army's Dental Services a High Reliability Organization.
- The Federal Government mandated the Patient Safety Program

What is Patient Safety?

Actions undertaken by individuals and organizations to protect health care recipients from being harmed by the effects of health care services.

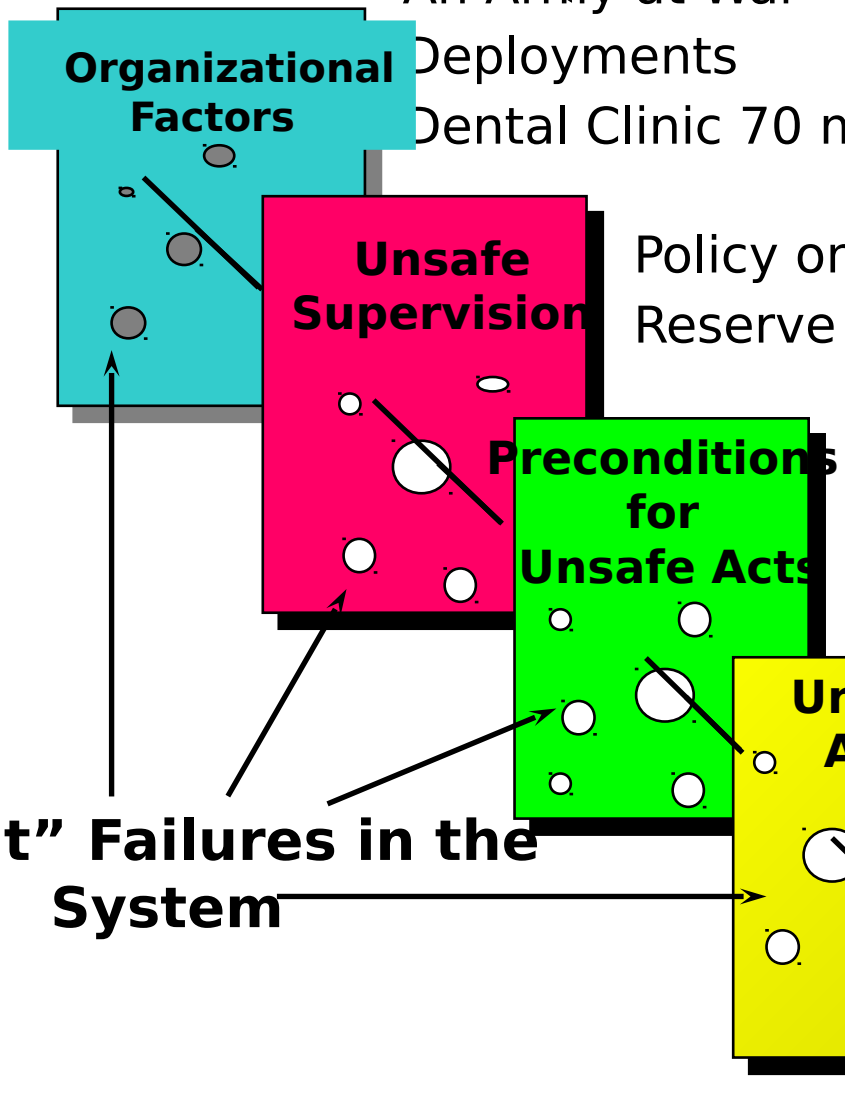

KOMATSU

Goals of Patient Safety Program

- **Reduce the risk injury to patients caused by treatment**
- **Remove or minimize hazards that increase risk**

The "Swiss Cheese" Model of Accident Causation

(Reason, 1990)



An Army at War

Deployments

Dental Clinic 70 miles from hospital

Policy on Dental Records

Reserve component

Patient "forgets" dental x-rays

"Time out" procedure not followed

Wrong Tooth removed

Latent" Failures in the System

Wrong Site Surgery

ACCIDENT & INJURY

How many people actually set out to do the wrong thing when they come to work?

How do we look at safety?

Individuals or system problems

Fix problems before they harm patients

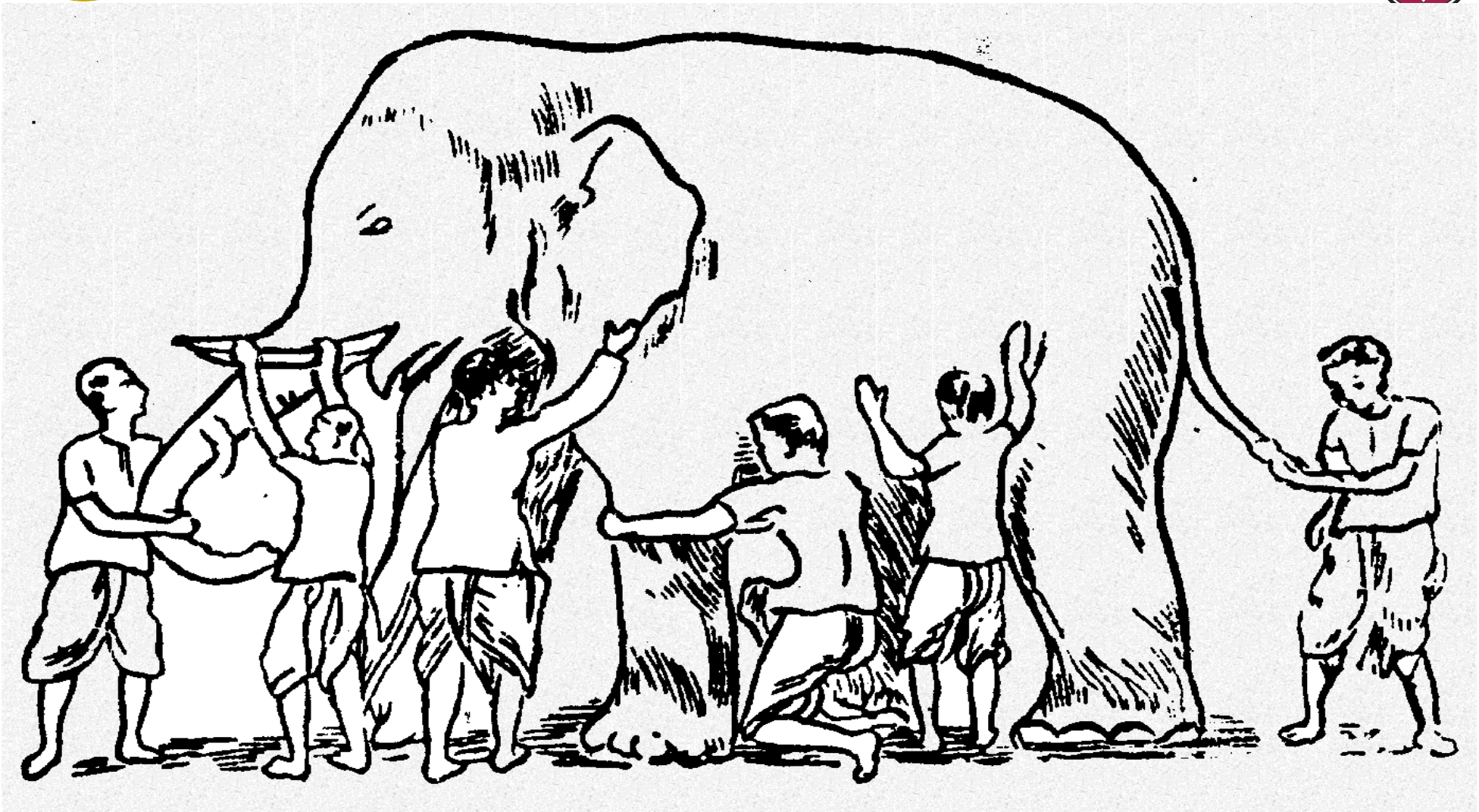
Actively speak up

Encourage the patient to ask questions

Give thanks to those who do look out for the safety of the patient

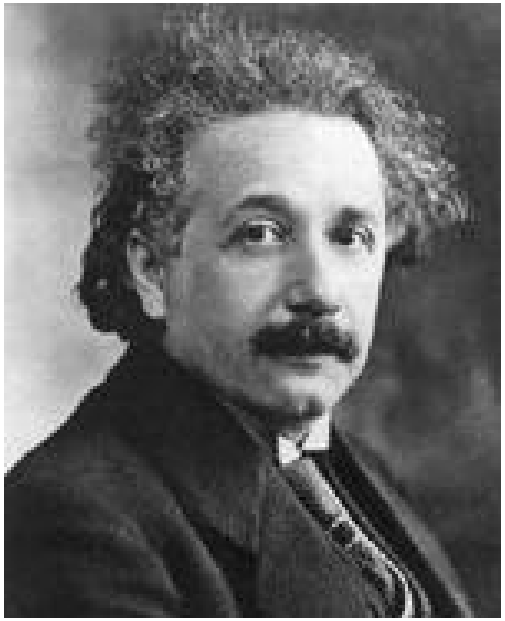
PS Program Priorities

- Event reporting and analysis
- Leadership culture – process and systems focused
- Staff culture - willingness to report patient safety events
- Education, training, & awareness



Examples of Dental Patient Safety events?

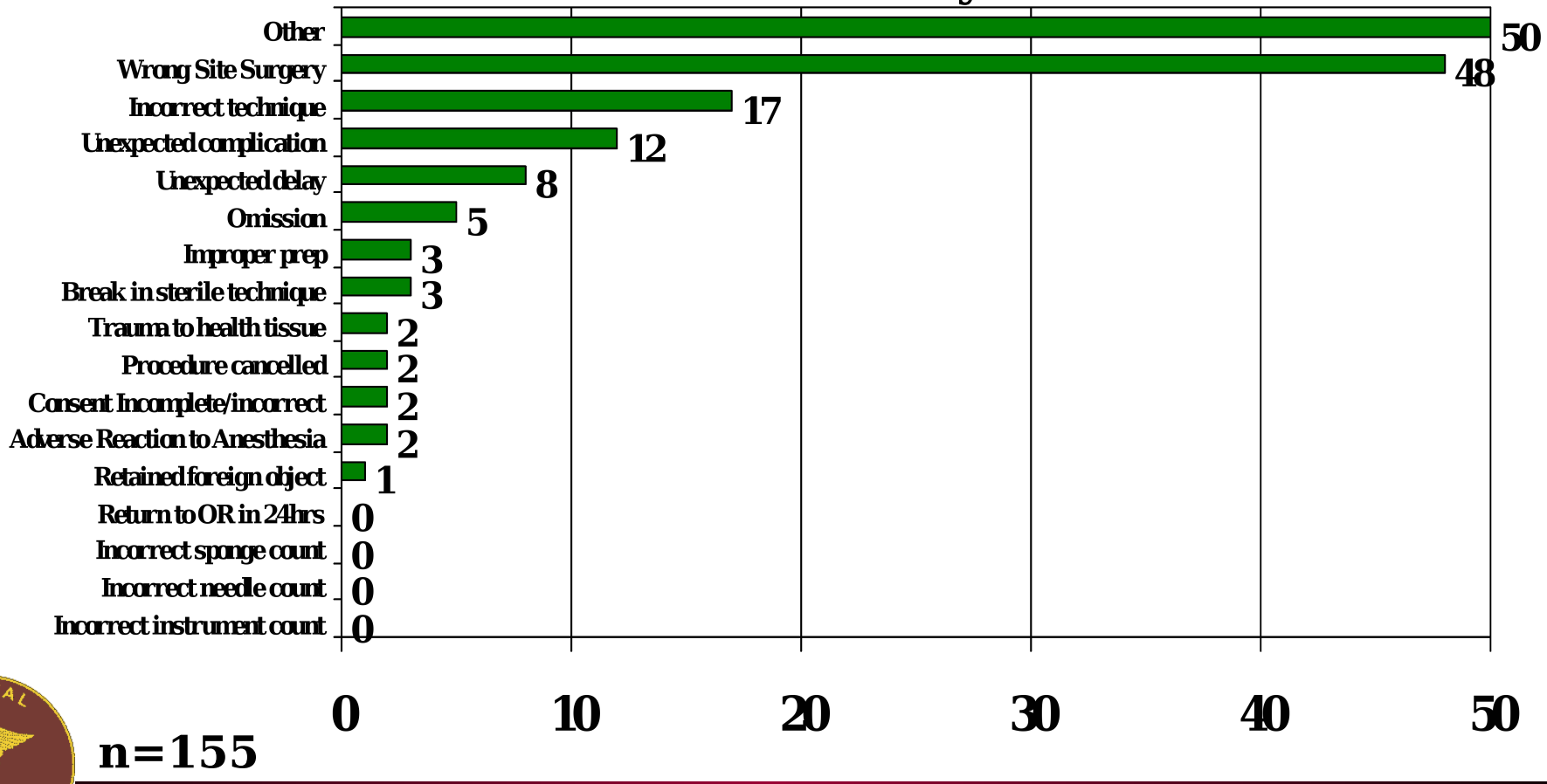
- Seating or treating the patient incorrectly “Wrong site surgery”
- Sterilization – non-sterile instruments used in patient care
- Swallowing/ aspiration of teeth or instruments “Retained foreign body”
- Radiographs: mounted up side down, incorrect view, incorrectly filed
- Equipment not properly maintained
- Lack of documented treatment plan



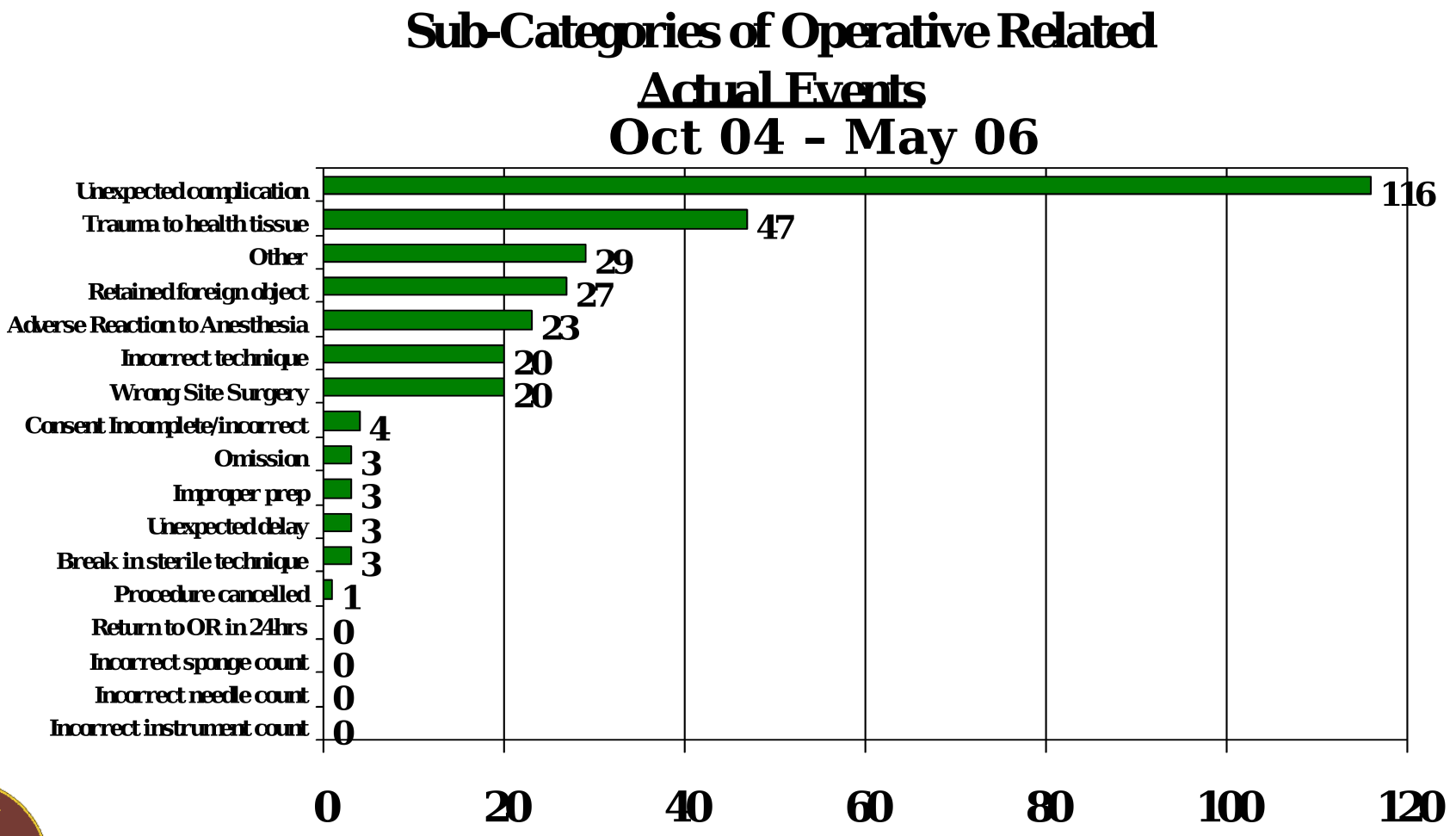
"Not everything that counts can be counted, and not everything that can be counted counts."

Sub-Categories of Operative Related Near Miss Events

Oct 04 – May 06

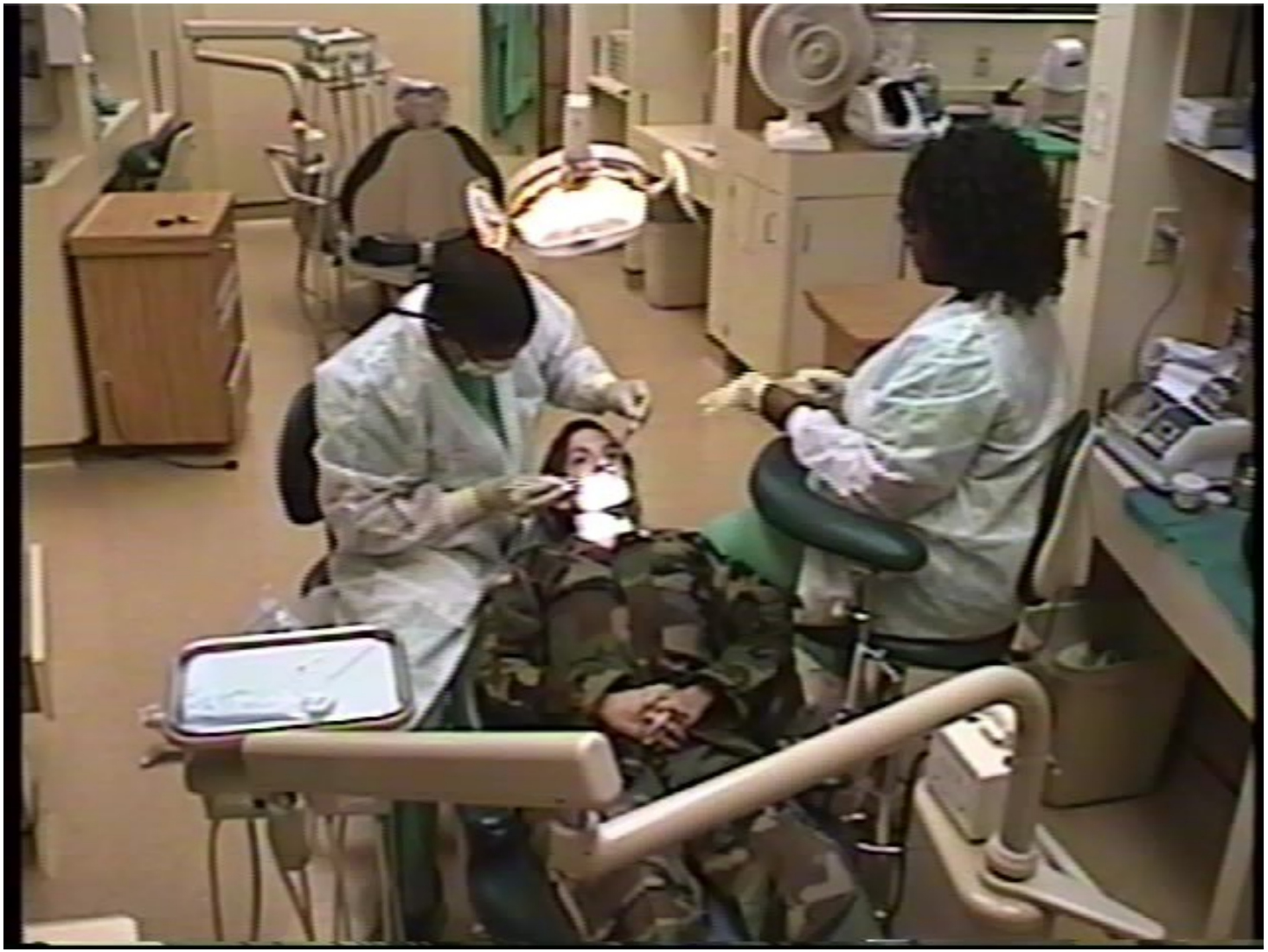


n=155


Sub-Categories of Operative Related
Actual Events
Oct 04 – May 06
Unexpected complication
Trauma to health tissue
Other
Retained foreign object
Adverse Reaction to Anesthesia
Incorrect technique
Wrong Site Surgery
Consent Incomplete/incorrect
Omission
Improper prep
Unexpected delay
Break in sterile technique
Procedure cancelled
Return to OR in 24hrs
Incorrect sponge count
Incorrect needle count
Incorrect instrument count
116
47
29
27
23
20
20
4
3
3
3
3
1
0
0
0
0
0
20
40
60
80
100
120

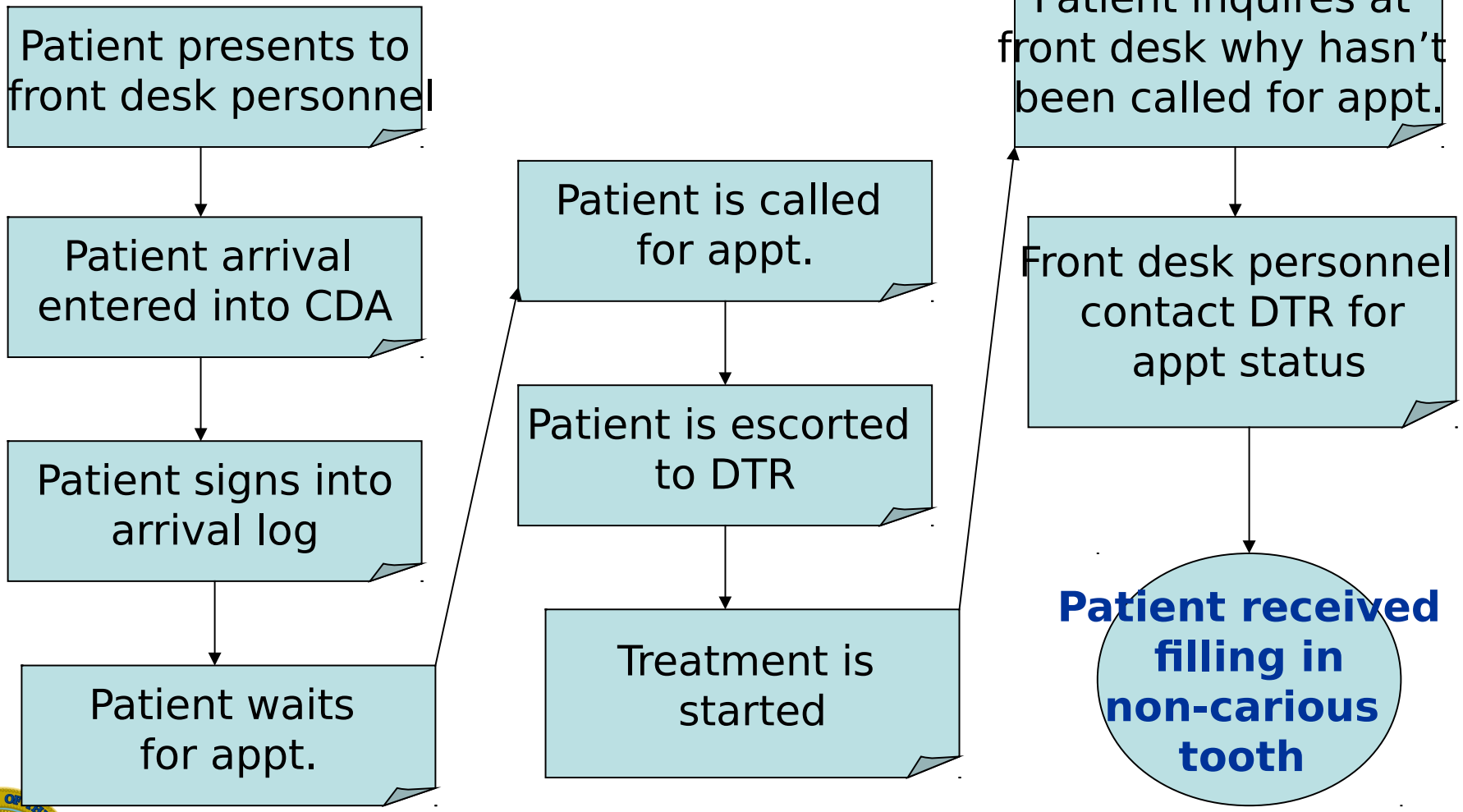
n=299

Wrong site surgery vignette




SPIN-A-CAUSE™
INATTENTION TO DETAIL
(Tell to Pay Attention
TRAINING
(Conduct More Training)
UNKNOWN
(Spin Again & Don't Tell Anyone!)
HUMAN ERROR
(Discipline Employee)
EQUIPMENT FAILURE
(Fix Equipment)
ASLEEP
(Wake-Up Employee & Fire)
ACT OF GOD
(Pray for a Solution)
SPIN-A-CAUSE™

Case 2: Wrong Patient Seated, Wrong Patient Treated



Corporate Strategies

- Wrong Site Surgery Policy
- Two patient identifiers
- Time out
- Mark x-rays

Break in Sterile Technique

Deployed soldier requires follow up protocol for exposure after being treated with unsterile instruments


SPIN-A-CAUSE™
INATTENTION TO DETAIL
(Tell to Pay Attention
TRAINING
(Conduct More Training)
UNKNOWN
(Spin Again & Don't Tell Anyone!)
HUMAN ERROR
(Discipline Employee)
EQUIPMENT FAILURE
(Fix Equipment)
ASLEEP
(Wake-Up Employee & Fire)
ACT OF GOD
(Pray for a Solution)
SPIN-A-CAUSE™

Break in Sterile Technique

Patient presents to DOD with buccal space infection requiring I&D

DOD and OMFS Resident on call treat patient without calling Dental Emergency Assistant on call

OMFS Resident prepped the room & obtained wrapped instrument set from an instrument cart parked outside the sterilization room.

Patient seated & tx rendered. Patient given post-op antibiotics and pain meds.

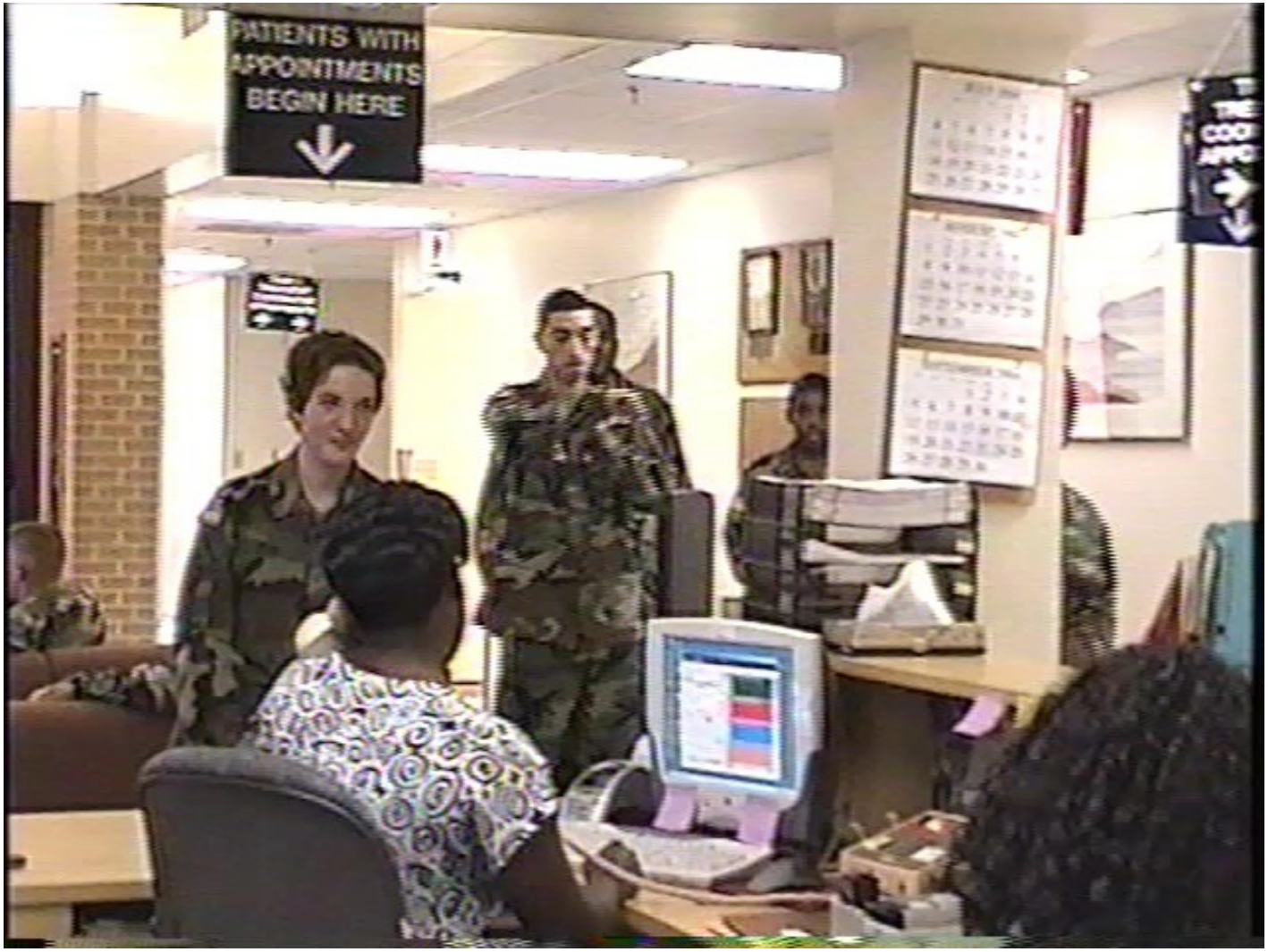
Dirty instruments covered and left for cleaning the next day

Patient treated with dirty instruments

Corporate Policy

- Create after hours policy
- Create procedure for contingencies when sterilizer is down
- Ensure instruments are checked for tape change

Chaos vignette



Culture Profile of a High Reliability Organization

LEADERSHIP ROLE

Patient is at the center of all we do

Safety is highest priority

Open environment to discuss errors

Team members encouraged to speak up

Rewards for safe actions

Training for hazardous situations

Support staff when an error ismade

Where is the baby?

How can we create a Safer Place for Patients?

- Team work/Communication
- Infection Control
- Time Out before procedures: right patient, procedure, side/level/site, equipment
- Emergency Situations – training simulation
- Radiographs
- Equipment failures – product recalls


TV

How can we improve team work to promote Patient Safety?

- Communicate
- Communicate respect for team members
- Command/leadership support for non-punitive reporting
- Two Challenge rule
- Team Huddle

TEAM HUDDLE

- A brief pause at the beginning of any procedure to describe the plan for the patient
- Done by the person performing the procedure

Two Challenge Rule

- Any team member has the responsibility when they see an unsafe condition to question twice
- Respectfully phrased
- Aware of Patient Presence
- Challenge twice
- Now what

THE ROANOKE TIMES
Monday, September 20, 2004

STEPHANIE KLEIN-DAVIS | The Roanoke Times

Mellisa Williamson, 35, a Bullitt Avenue resident, worries about the effect on her unborn child from the sound of jackhammers.

Putting Patients in Patient Safety

- Education
- Health Literacy
- Listen
- Medications/ discharge instructions
- Informed consent
- Encourage participation
- Be a participating patient:
  - Know your medications
  - Request caregivers identify you appropriately
  - Request handwashing
  - Request information you can understand

Resources

REGULATORY

- DoD 6025.13
- AR 40-68 Quality Management in AMEDD
- MEDCOM Reg 40-41, The PS Program
- MEDCOM Cir 40-17, Surgical Site Verification

Patient Safety Materials

www.QMO.amedd.army.mil

Veterans Administration

www.patientsafety.gov

Think Change
Think Communication
Think Safety
Think Patient